Postpartum Pulmonary Embolus

Set-up:	Manikin is Supine sat up 30 degrees, clean wound dressing over lower abdomen
Lines/access:	1x 16G cannula
Infusions:	Nil
Airway:	Patient's own, patent
Ventilator:	N/A
Other:	There is no embolectomy, mechanical thrombectomy or eCPR service in this hospital

Clinical Setting:

I: You are the ITU outreach doctor, called to a medical emergency on maternity HDU

S: You have been called to the postnatal ward to review a woman who is hypotensive and tachycardic post c-section.

B: 32F Fit and well G1P0 at term 40/40, prolonged labour, emergency c-section 12 hours ago. PPH 1.2L due to some difficulty in getting bleeding control, taken to maternity HDU post op for monitoring due to haemorrhage.

A: HR 115 BP 90/70 T 36.9 sats 92% RR 20

R: Called for help

Potential Clinical Course:

- Patient is GCS 15 talking but very agitated, complaining of chest pain on inspiration and dizziness. Candidate would be expected to apply high flow O2, get a second access and take bloods/VBG. ECG if asked for one shows right heart strain.
- If patient exposed – there is a unilateral swollen left leg.
- Help to be called early, Obstetric team to be called early (obstetric SpR arrives early, ITU consultant is en route)
- Patient becomes increasingly drowsy, increasing tachycardia decreasing blood pressure
- Candidate to consider central access, arterial line, vasopressors, high dose LMWH and ultimately thrombolysis as definitive management.
- Final decision for thrombolysis, in safe setting with senior presence on both obstetric and ITU sides is end of scenario. Consideration of transfer to unit with mechanical thrombectomy of ECMO facilities.

This Simulation Scenario has been written by Dr Genevieve Almond, the document has been produced by Dr Melia and approved by the FICM Education Sub-Committee. If you have any queries, please contact FICM via contact@ficm.ac.uk.

The Faculty of Intensive Care Medicine

Info Sheet For Faculty

- Initial obs:
  - GCS E4V5M6
  - HR 115
  - BP 90/70
  - Sats 92%
  - RR 20
  - ABG: Hb 88 pH 7.51 PCO2 3.2 O2 8.9 on RA
- Progress to:
  - GCS E2V3M5
  - HR 120
  - BP 75/40
  - Sats 89%
  - RR24

- Further observations depend upon actions; high flow oxygen improves sats, fluid improves blood pressure marginally but not above 90/70

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The Faculty of Intensive Care Medicine

Faculty Roles:

Midwife in postnatal ward:

- You normally work on the birthing centre but have been asked to cover postnatal ward due to staff shortages.
- You were handed over this patient from recovery who had a cat 3 emergency section for failure to progress. She had 2 doses of uterotonics, TXA and an EBL of 1.2L. Baby is well.
- The patient was well when you received her but over the course of 2 hours has become increasingly uncomfortable, complaining of tightness in her chest and feeling dizzy.
- There has been no further bleeding, the wound dressing looks clean.
- Her RR has gone up to 20 and her HR is high, she looked a bit grey which is why you put out a medical emergency call.
- You don't think it's a good idea to give anticoagulation after a PPH of 1.2L
- You have not used High Flow O2 before.

Obstetric SpR:

- You were called to see this unwell patient by the midwife looking after her
- You are concerned about post op bleeding, but the bleeding was well controlled when you closed
- If the candidate is concerned her current condition is related to the PPH suggest that this isn't a major haemorrhage in obstetrics as <1.5L, you were happy that the bleeding has stopped, and your examination alongside stable Hb makes you think this is something other than bleeding
- You get a bit annoyed by the suggestion that she would still be bleeding, after closure
- If asked about the decision to for thrombolysis, would state you would need to involve your consultant who is currently in clinic. You also highlight that she's not even had any scans done. If pushed you can call your consultant, they advise prepare reduced dose systemic thrombolysis and they will come to assist.

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